HAWAII ELECTRICIANS HEALTH & WELFARE FUND

1935 Hau Street, Room 300, Honolulu, Hawaii 96819 ▪ Telephone: (808) 841-6169 ▪ Toll Free: 1 (800) 622-3830 ▪ Facsimile: (808) 842-4281

SPOUSE / DEPENDENT QUESTIONNAIRE

Please complete this form if you are a new member with a dependent spouse/children. Failure to submit this form may result in a delay of coverage for your dependents.

MEMBER NAME (Last, First, Middle Initial)	**Date of Birth**	**Social Security Number**
	/ /	
Address (Street, City, State, Zip Code)	**Home Phone**	**Cell Phone**
	( )	( )

MARITAL STATUS: ☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widowed

Effective Date: ____/____/____

SPOUSE NAME (Last, First, Middle Initial)	**Date of Birth**	**Social Security Number**
	/ /	

FOR H&W FUND OFFICE USE ONLY

❑ **NEW** ❑ **ADD DEPENDENT**

Effective Date ____________

Member ID# ____________

STAT Date ____________ ELIG Date ____________

❑ M-CERT ❑ B-CERT ❑ SSN ❑ DECREE ❑ QMCSO
❑ PAT-AFF ❑ STEP-AFF ❑ DIV-AFF

REMARKS:

___ SYS36 ____ MED ____ RX ____ DENTAL ___ VISION

DEPENDENT(S) NAME	Gender	Date of Birth	Social Security	Child lives with:	Check all that applies:	
	❑ Male ❑ Female	/ /		❑ You ❑ Other parent	❑ F/T Student ❑ Disabled	❑ Stepchild ❑ Adopted
	❑ Male ❑ Female	/ /		❑ You ❑ Other parent	❑ F/T Student ❑ Disabled	❑ Stepchild ❑ Adopted
	❑ Male ❑ Female	/ /		❑ You ❑ Other parent	❑ F/T Student ❑ Disabled	❑ Stepchild ❑ Adopted
	❑ Male ❑ Female	/ /		❑ You ❑ Other parent	❑ F/T Student ❑ Disabled	❑ Stepchild ❑ Adopted
	❑ Male ❑ Female	/ /		❑ You ❑ Other parent	❑ F/T Student ❑ Disabled	❑ Stepchild ❑ Adopted

Is your spouse currently employed? ❑ No ❑ Yes (If "YES", please complete this section) **Occupation:** ____________

Employment Status (check one): ❑ Full Time ❑ Part-Time (Avg # of hrs/wk _______) ❑ Self-Employed

Employer Name ____________ **Address** ____________ **Telephone** ( )

Does your spouse have health coverage through his/her employer? ❑ Yes ❑ No **Effective Date** / /

Carrier Name ____________ **Group #:** ____________ **Subscriber #** ____________

Coverage Type:
☐ Medical ☐ Drug ☐ Dental
☐ Vision ☐ Supplemental

Plan Type:
☐ Single ☐ Family
☐ Subscriber & Children

(List name(s) of all dependents covered under this plan)
____________ ____________ ____________
____________ ____________ ____________

Are any of your dependent children employed 20 or more hours per week? ❑ No ❑ Yes (If "YES", please complete this section)

Dependent Name ____________ Avg # of hrs/wk: ________ **Occupation:** ____________

Employer Name: ____________ Address ____________ **Telephone** ( )

Does dependent have health coverage through his/her employer? ❑ Yes ❑ No Coverage Type: ☐ Medical ☐ Drug ☐ Dental ☐ Vision

Carrier Name ____________ Policy No. ____________ Subscriber ID# ____________ Effective Date: / /

DEPENDENT CHILDREN/STEPCHILDREN COVERAGE

If any of your dependents are from a previous marriage, born out of wedlock or stepchild(ren), please complete the following:

Name of dependent child(ren): ____________________ ____________________ ____________________

Are any of the dependent children covered for health benefits under the other biological parent? ☐ Yes ☐ No **Effective Date:** ____/____/____

Name of the other biological parent: ______________________________ **Date of Birth:** ____/____/____

Carrier Name: ____________________ **Policy No:** ____________________ **Subscriber ID#:** ____________________

If you are divorced, check one of the following:

❑ Divorce decree stipulates the other parent must provide benefits ❑ Divorce decree stipulates joint custody ❑ Decree does not stipulate special provisions

Name of custodial parent: ____________________ Mailing Address: ______________________________

If you have a court order to provide medical coverage for any of the dependent children, please complete the following:

Date of Order: ____/____/____ Effective Date: ____/____/____ Child Name: ____________________

Custodian Name: ____________________ Mailing Address: ______________________________

(Attach copy of divorce decree and/or court order)

MEDICARE COVERAGE

Are you or any of your dependents enrolled in Medicare? ☐ Yes ☐ No **(If "YES", please complete the following):**

Name of person eligible for Medicare: ______________________________ **Medicare No.** ____________________

Reason for Medicare: ❑ Age 65 or older ❑ Disability due to ____________________ ❑ ESRD / Date Dialysis Treatment Began: ____/____/____

Type of Coverage: Part A (Hospital) (_____/_____/_____) Part B (Medical) (_____/_____/_____) Part D (Drug) (_____/_____/_____)

(Attach a copy of your Medicare Card)

OTHER HEALTH CARE COVERAGE

Do you or your dependents have any other coverage (i.e., previous employer, TRI-CARE)? ☐ Yes ☐ No **(If "YES", please complete the following)**

Subscriber Name: ____________________ **Subscriber ID #:** ____________________ **Effective Date:** ____/____/____

Carrier Name: ____________________ **Policyholder:** ____________________ **Group No:** ____________________

Coverage Type: ☐ Medical ☐ Drug ☐ Dental ☐ Vision ☐ Supplemental **Plan Type:** ☐ Single ☐ Family ☐ Subscriber & Spouse ☐ Retiree

I/We understand that the Fund is relying on this information to determine eligibility for medical benefits for myself and my dependents. I/We understand that it is unlawful for me to make any statements which I/we know is untrue, false or misleading. I/We declare and affirm in good faith and under perjury under Federal and State laws that the information provided herein in true and correct to the best of my knowledge and I/We consent to the provisions stated above on this form which I/We have read and fully understand. I/We also understand that the penalty for committing perjury may be a fine or imprisonment, or both, and may also result in a legal claim against me for recovery or offset of benefits improperly paid to be or my dependents based on the information provided herein.

______________________________ ____________________ ______________________________ ____________________

Member Signature **Date** **Spouse Signature** **Date**